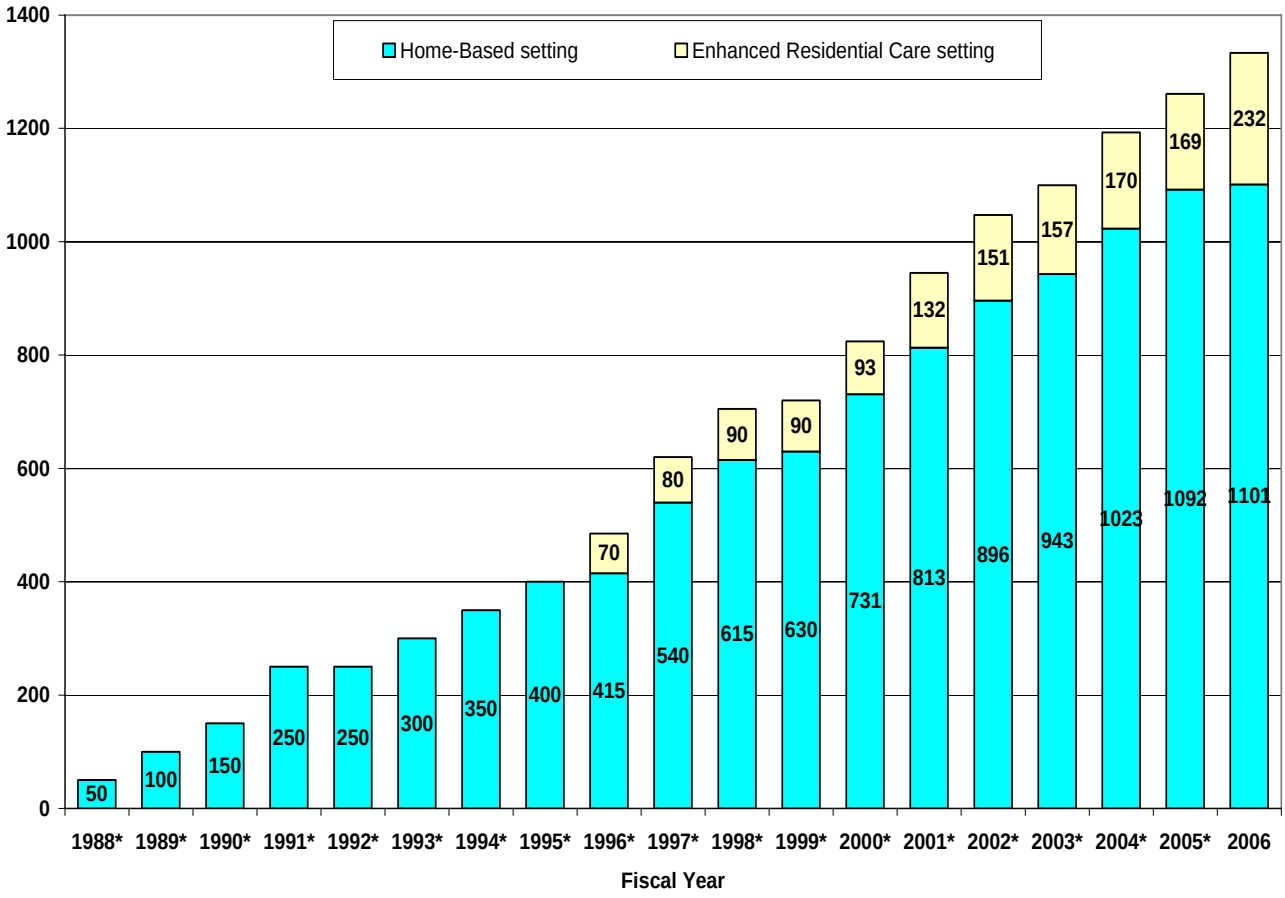
Choices for Care
Quarterly Data Report
December 2006

This report presents recent data that documents the status and progress of Choices for Care. Taken together, this data is intended to provide useful insight into the enrollment and service trends within Choices for Care. A brief explanation accompanies each graph, chart or table.

The primary data sources are SAMS Choices for Care enrollment and service authorization data maintained by the Division of Disability and Aging Services, and Medicaid claims data maintained by EDS.

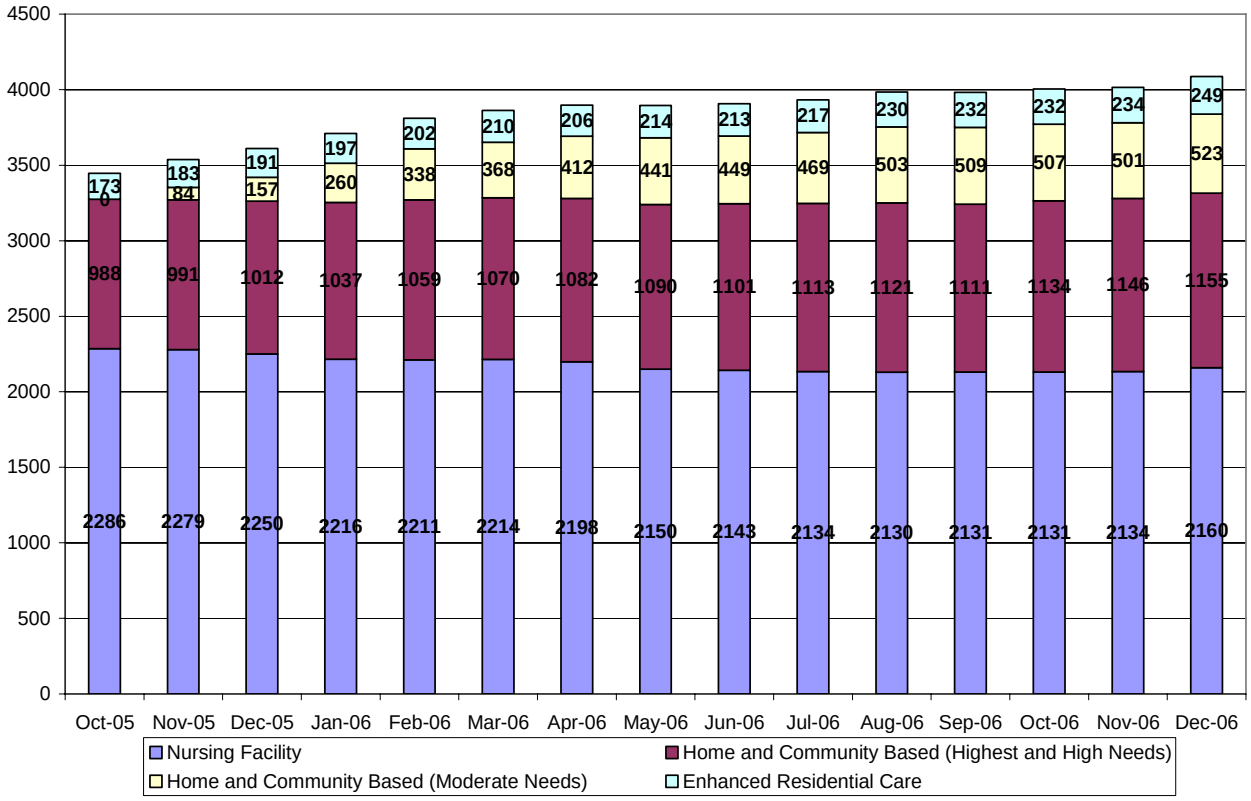
Bard Hill
Information and Data Unit
Division of Disability and Aging Services
Department of Disabilities, Aging and Independent Living
Agency of Human Services
103 South Main Street – Weeks Building
Waterbury, Vermont
05671-1601
802.241.2335
TTY 802.241.3557
Fax 802.241.4224

Numbers of People Served in Aged/Disabled Medicaid Waivers
Maximum Number Within Year, sfy1988-sfy2006
(does not include moderate needs group)



This graph illustrates the controlled growth in home and community based services in Vermont prior to the implementation of Choices for Care. This growth was fairly steady but limited by funding. During this time period all eligible Vermonters were entitled to nursing home care, while some people who applied for home and community based care were placed on waiting lists...

Choices for Care: Total Number of Enrolled Participants
October 2005 - December 2006



Data source: DAIL/DDAS SAMS database.

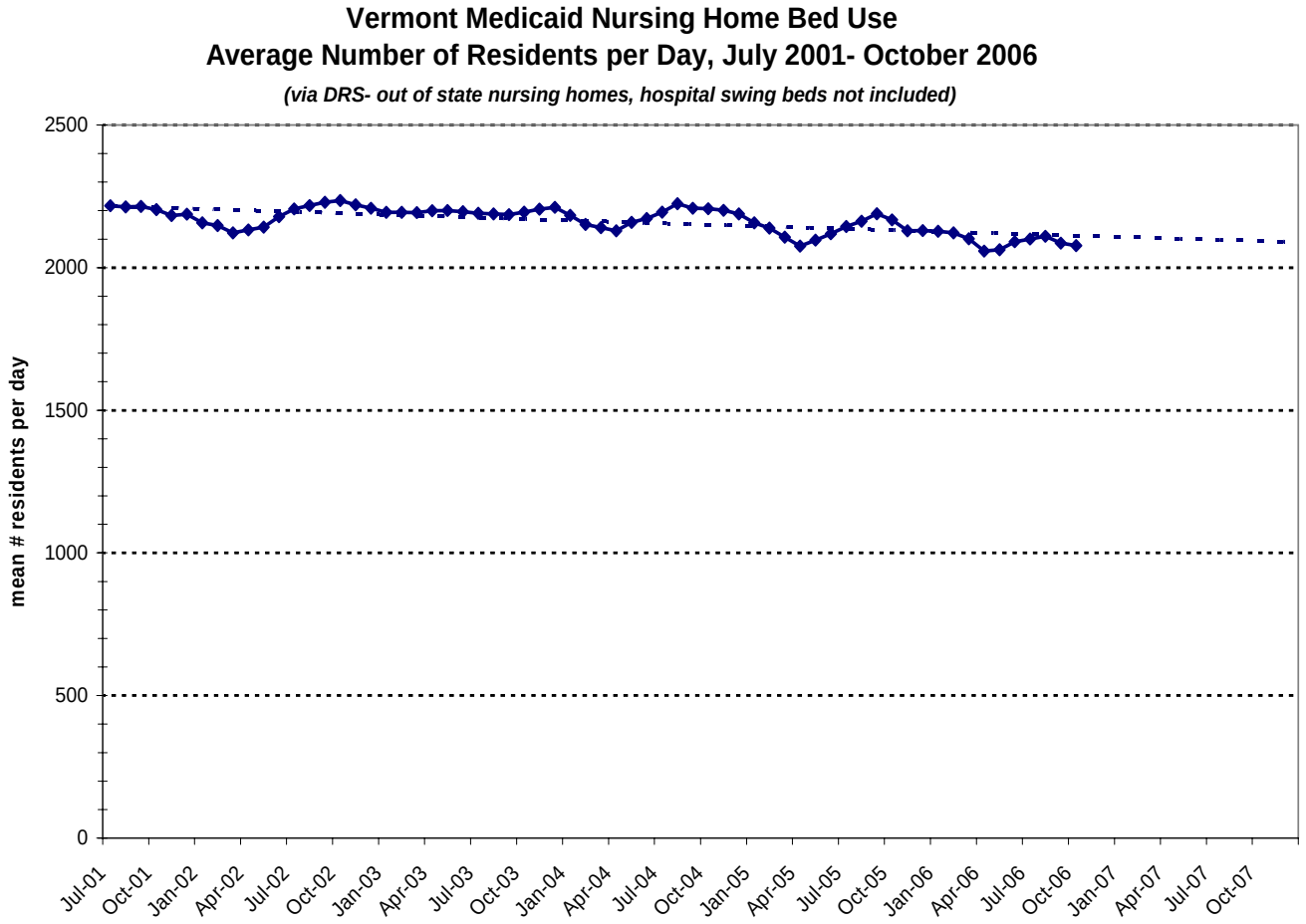
This graph shows the number of participants enrolled in each Choices for Care setting since inception (October, 2005). The number of people served in nursing homes has decreased, while the numbers of people served in the Home and Community Based and Enhanced Residential Care settings have increased:

1. Nursing homes: the number of people in nursing homes under Medicaid decreased by 126 (from 2,286 to 2,160) between October, 2005 and December, 2006.

2. Home and Community Based Services (Highest/High Needs Groups): the number of people increased by 167 (from 988 to 1,155) between October, 2005 and December, 2006.

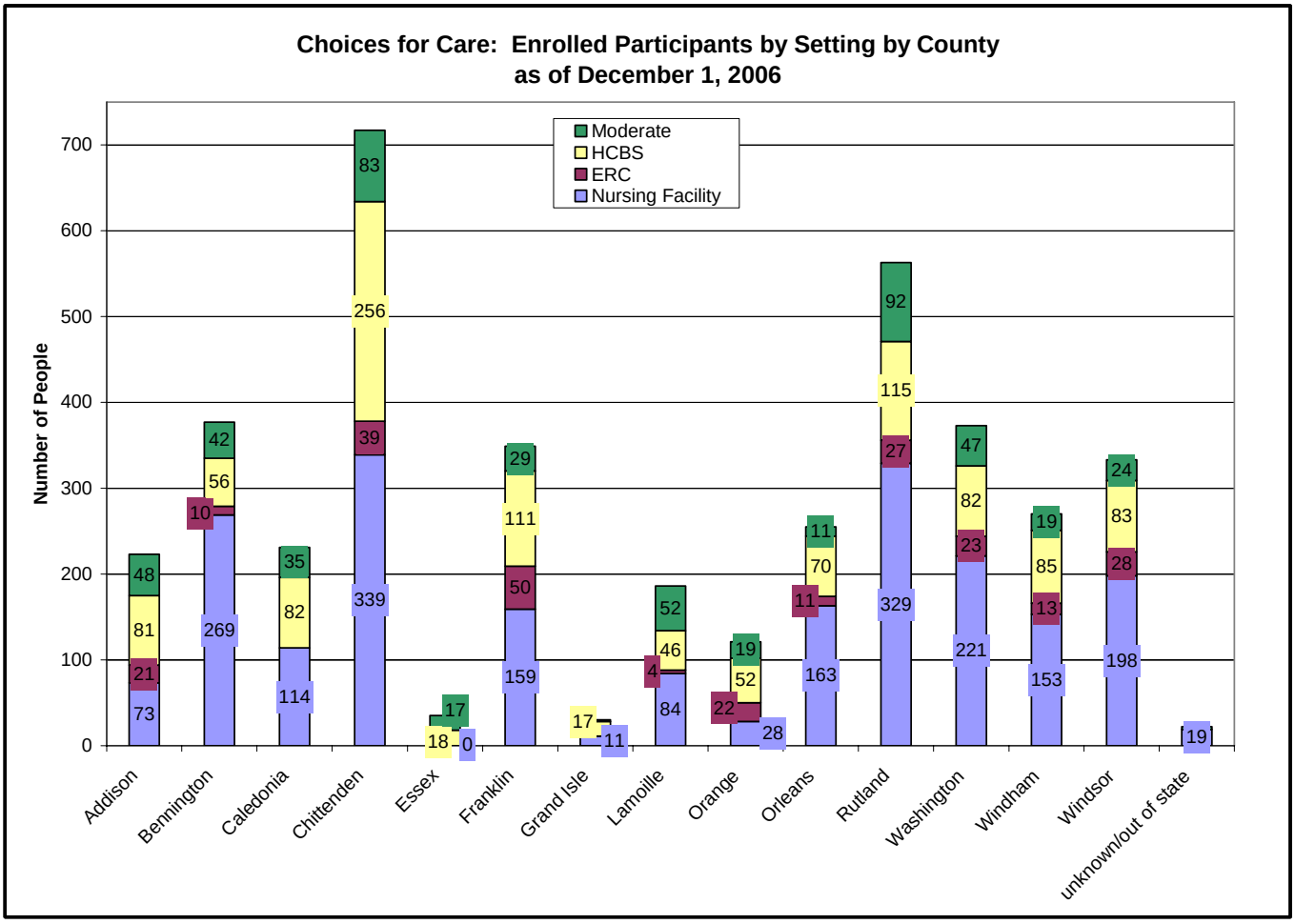
3. Enhanced Residential Care: the number of people increased by 76 (from 173 to 249) between October, 2005 and December, 2006.

4. HCBS Moderate Needs Group: the number of people increased from 0 to 523 between October, 2005 and December, 2006.



Data source: Agency of Human Services Division of Rate Setting, reported resident days by month.

This graph represents the number of nursing homes days with Medicaid as the primary payer each month, as reported by Vermont nursing homes to the Division of Rate Setting. Consistent with the previous Choices for Care data, this shows a slow decrease in the use of nursing homes by Medicaid residents.

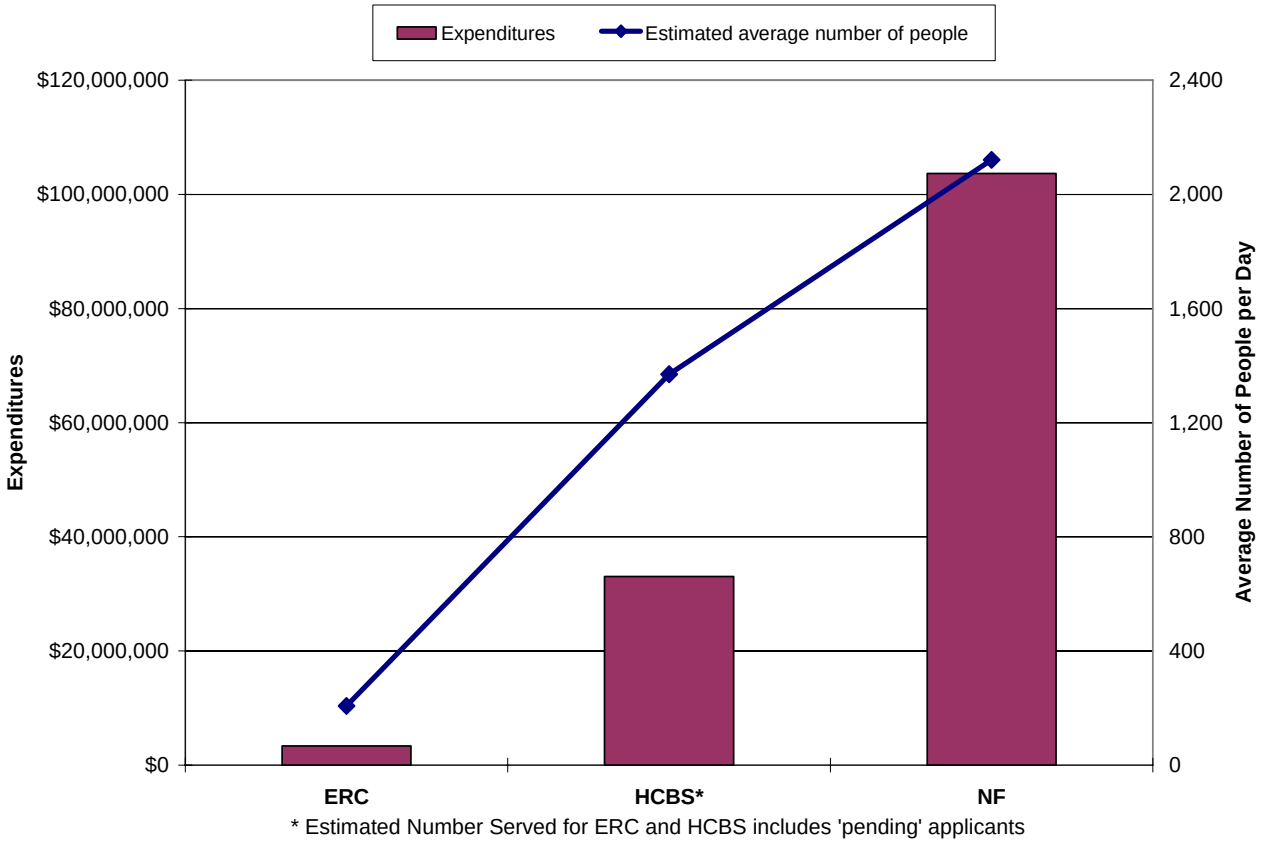


Data source: DAIL/DDAS SAMS database.

This shows the settings in which Choices for Care participants are served, by county. The graph can be used to compare the relative numbers of people served in each county, and to compare the relative numbers of each people in each setting.

Chittenden County, with the largest population in Vermont, has the highest number of Choices for Care participants. In Addison and Orange Counties, a relatively large number of people in the Highest and High Needs Groups are served in the HCBS and ERC settings. In Bennington County, a relatively large number of people in the Highest and High Needs Groups are served in the Nursing Facility setting.

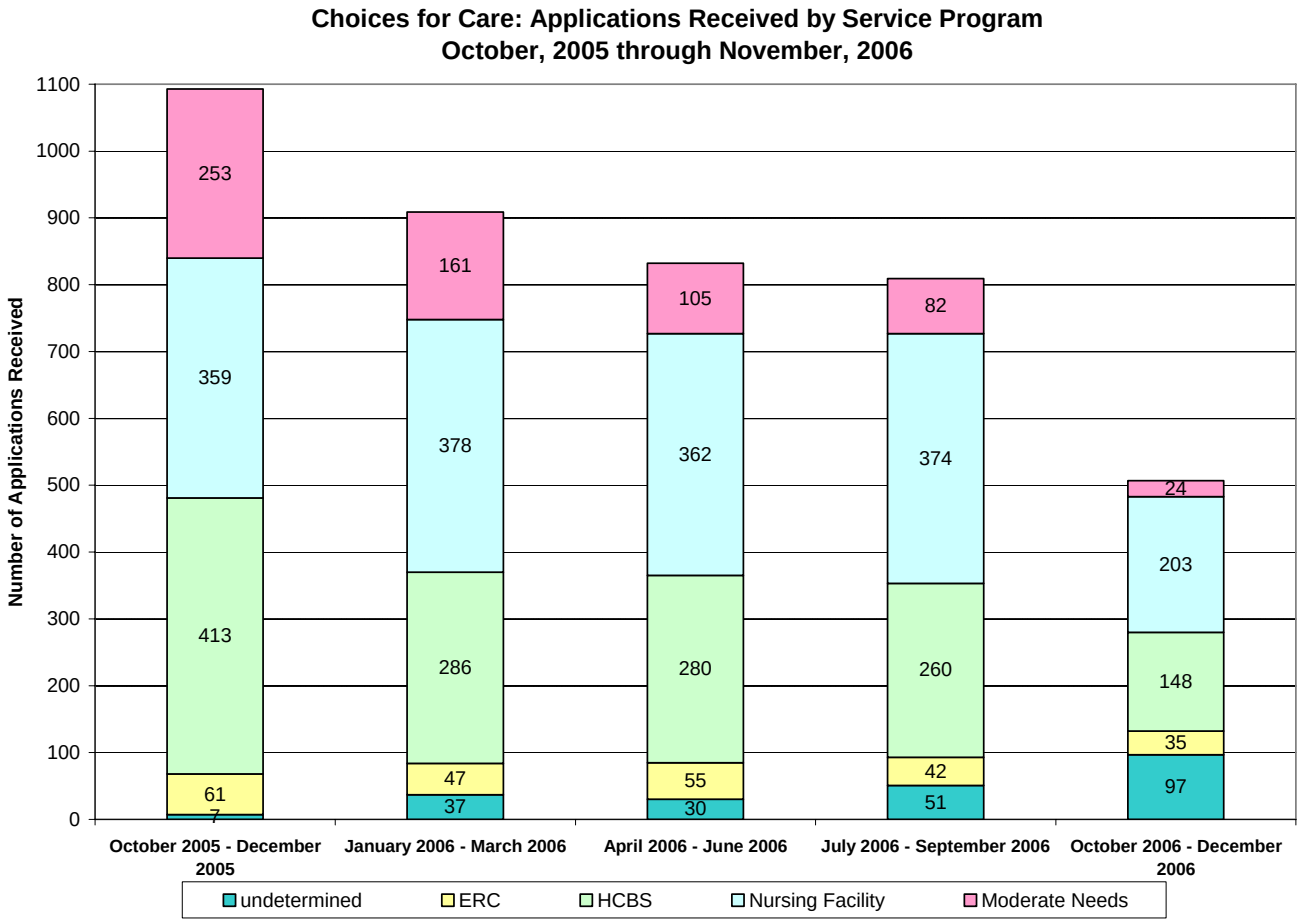
Choices for Care: Long Term Care Expenditures and Average Number of People Served per Day, SFY2006



Data source: AHS cash payments by type, CFC monthly monitoring report.

This shows Medicaid long term care expenditures and estimated numbers of people served by setting in state fiscal year 2006.

About 74% of the expenditures were in the nursing facility setting, while 24% were in the HCBS setting and 2% were in the ERC setting. In comparison, on an estimated average day, 57% of the people were served in the nursing facility setting, while 37% were in the HCBS setting and 6% were in the ERC setting. (Note: the estimated numbers of people served in the HCBS and ERC settings include 'pending' applicants, which inflates these numbers by a modest percentage.)

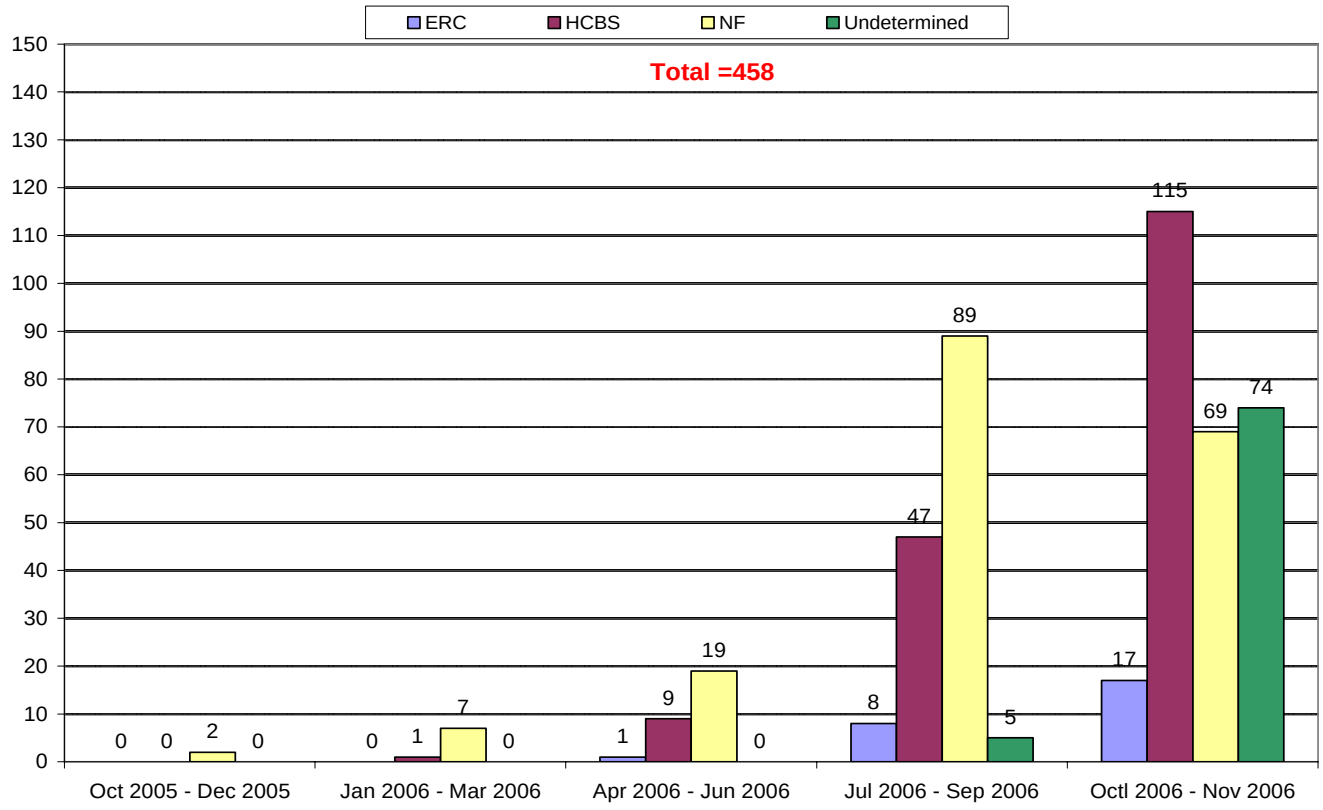


Data source: DAIL/DDAS SAMS database.

DAIL received 505 Choices for Care applications in October 2005, significantly more than in any subsequent month. The pent-up demand represented by people on preexisting waiting lists for HCBS and ERC services (241 people in September 2005) contributed to this large number of applications.

While the monthly number of applications received after October 2005 has declined, most of this decline is due to a decrease in the number of applications for the Moderate Needs Group. DAIL/DDAS continues to receive an average of about 250 applications per month. Nearly half of the applications are for Nursing Facilities (including short-term and rehabilitation nursing home admissions under Medicaid.) About 35% of the applications are for Home and Community Based Services, and about 7% are for Enhanced Residential Care.

Choices for Care: Pending and Received Applications by Date of Application by Service Program
October, 2005 through November, 2006
as of 12.1.06



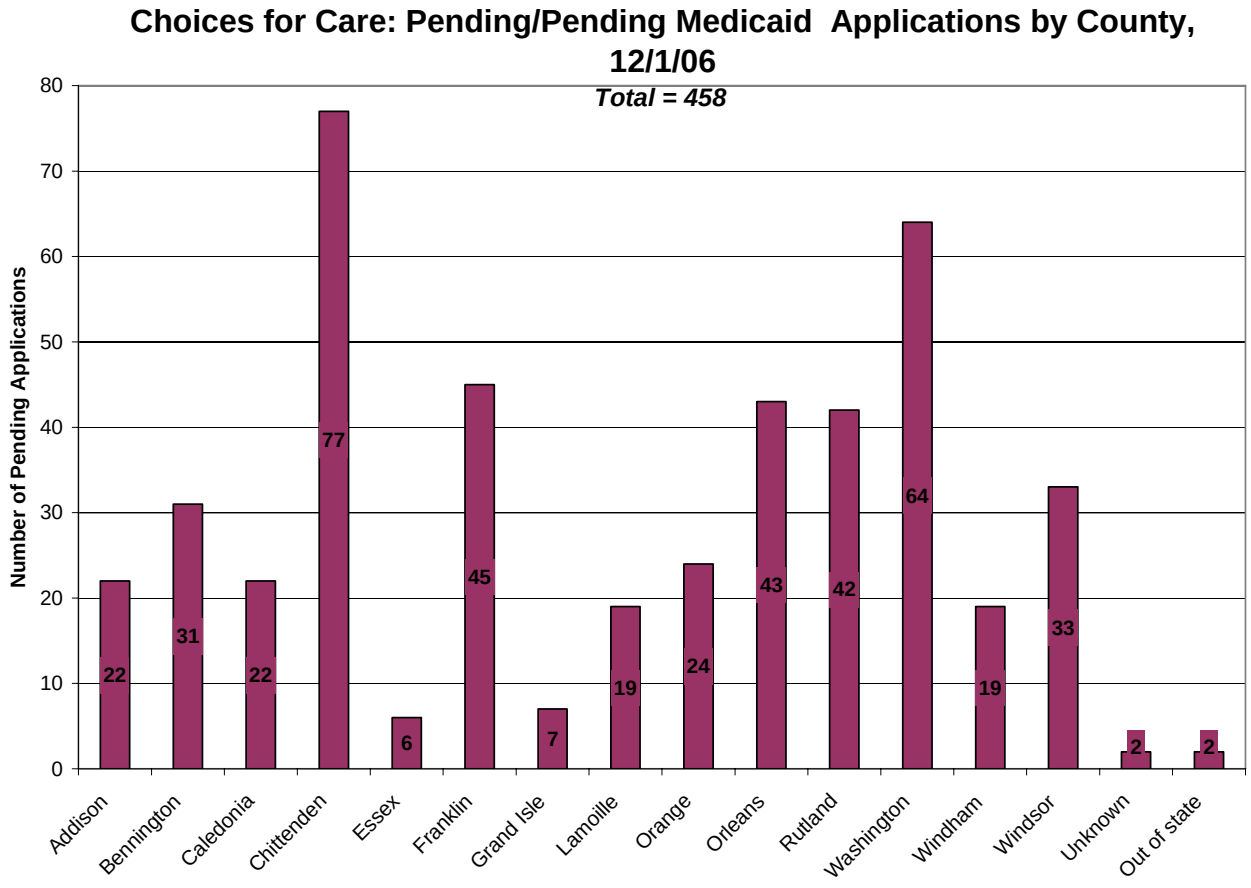
Data source: DAIL/DDAS SAMS database.

One of the goals of Choices for Care is to process individual applications in a timely manner. This graph shows the months in which pending applications were received.

While many applications are fully processed within eight weeks, a small number remain pending for many months. DAIL data shows that 95% of the applications received before July 1 have been fully processed, 80% of those received before October 1, and about 40% of those received after October 1. Common causes for delays in determining Medicaid eligibility include:

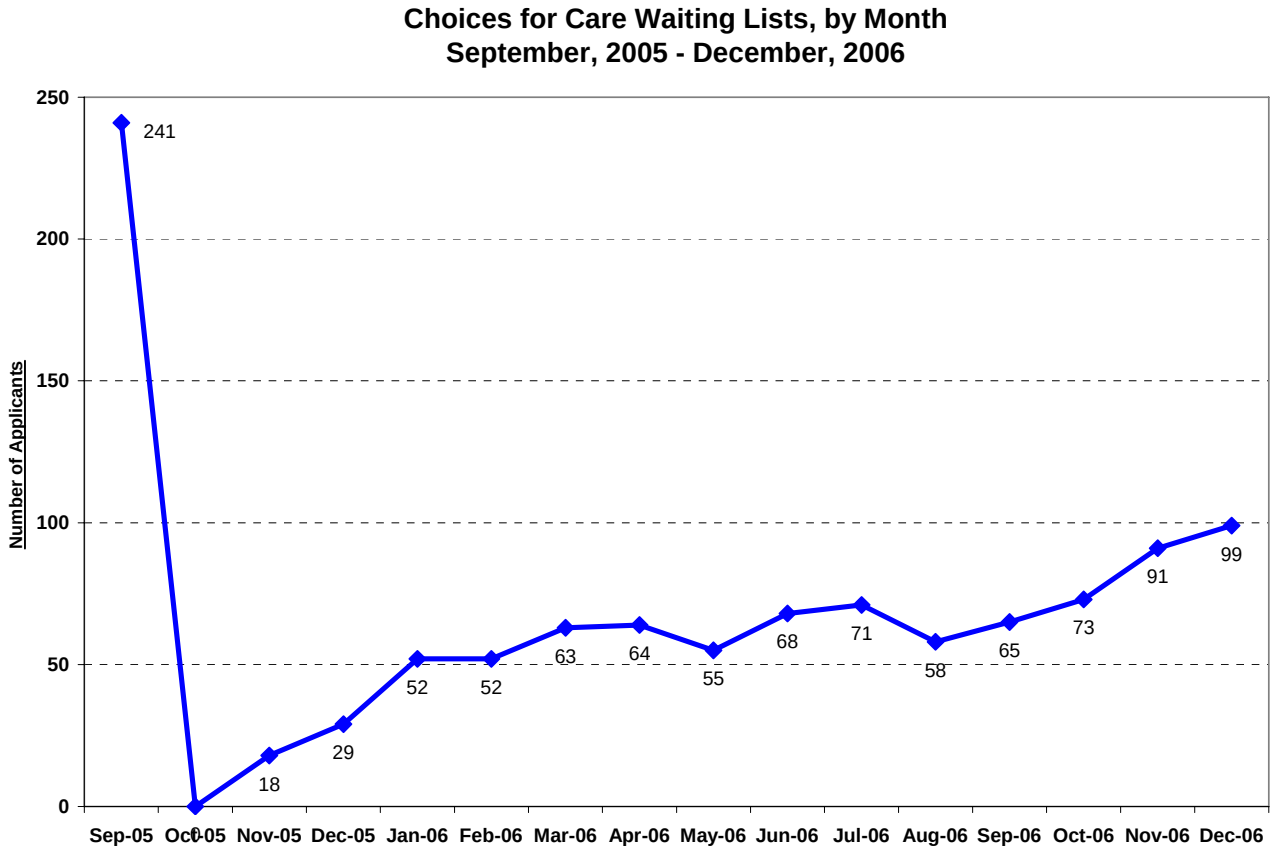
1. Long-term care Medicaid applications are not submitted.
2. Long-term care Medicaid applications are delayed or incomplete.
3. Some applicants under the age of 60 (those not already eligible for SSI) are required to undergo a Disability Determination process, which routinely requires several months.
4. Some applications lead to complicated asset searches and/or legal review by the Department for Children and Families (DCF).

Staff from DAIL and DCF continue to work together to find ways to process applications as quickly as possible.



Data source: DAIL/DDAS SAMS database.

Applications are pending in every Vermont county. Two counties with large populations (Chittenden and Washington) also have large numbers of pending applications, while two other counties with large populations (Rutland and Windsor) do not. Some counties with smaller populations have a relatively large number of pending applications (eg Orleans).



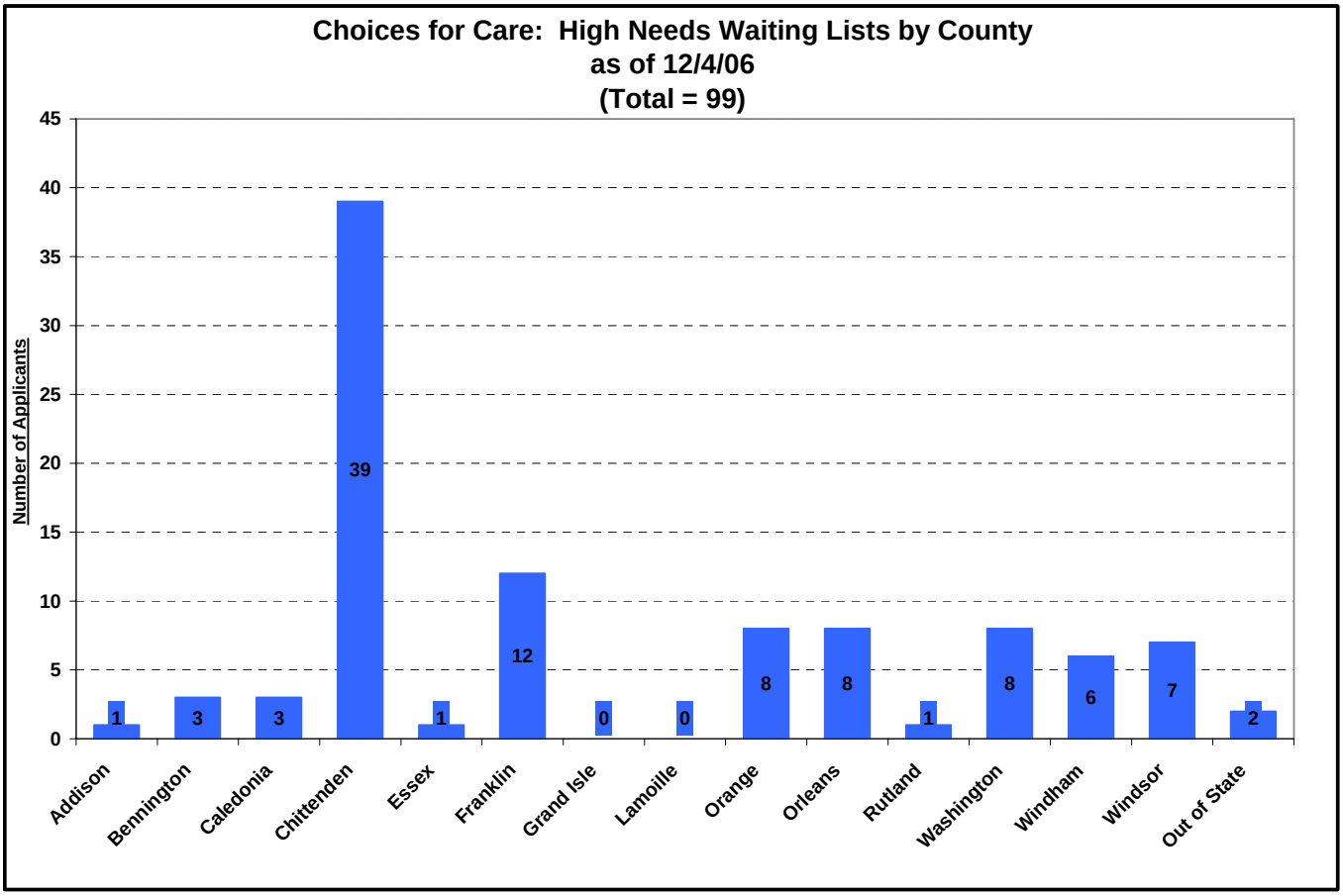
Data source: DAIL/DDAS SAMS database.

Applicants who meet the High Needs Group eligibility criteria are currently placed on a waiting list. The number of people on this waiting list has slowly increased over time.

Prior to the implementation of Choices for Care, access to Home and Community Based Services and Enhanced Residential Care were limited by available funds, and many applicants were routinely placed on waiting lists. The total number of people on waiting lists fell substantially when Choices for Care was implemented in October 2005, when all applicants who met Highest Needs Group eligibility criteria became entitled to services.

Some people from the waiting list have been admitted under special circumstances or because their needs increased so that they met the Highest Needs Group eligibility criteria. This includes 41 people admitted to Home and Community Based Services, 2 people admitted to Enhanced Residential Care, and 2 people admitted to nursing facilities.

Based on the availability of funds, 11 people from the High Needs Group waiting list were enrolled in Choices for Care during July 2006. Discussions have begun regarding the possibility of enrolling a second group of people from the waiting list.



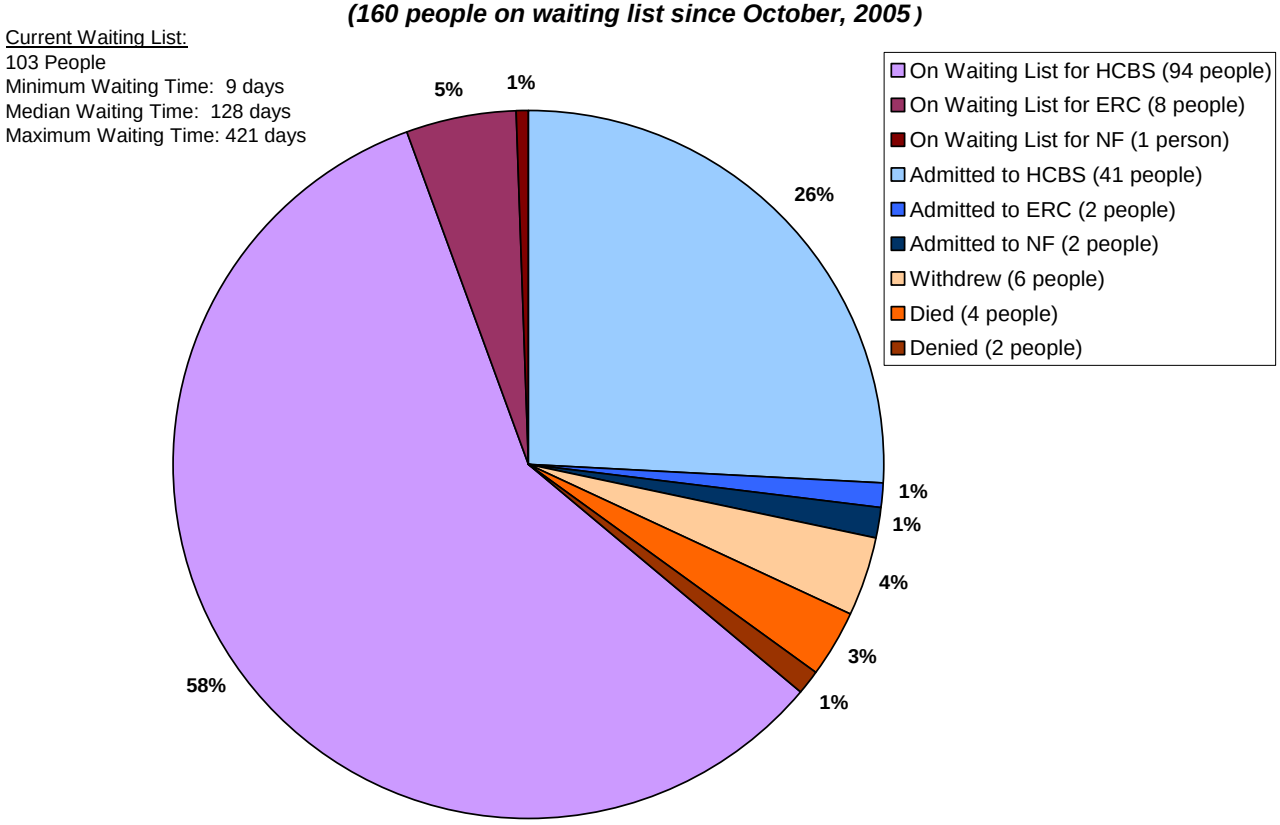
Data source: DAIL/DDAS SAMS database.

Nearly every county has at least one person on the High Needs waiting list. Applicants from Chittenden County represent the single largest group on the waiting list, as they had prior to Choices for Care. Applicants from Chittenden County on the high needs waiting list represent about 40% of the total, while about 25% of the state's population resides in Chittenden County.

Two other counties with large populations (Rutland and Washington) have small numbers of applicants on the waiting list, while several modestly sized counties (Franklin, Orange and Orleans) have a relatively large number of applicants on the waiting list.

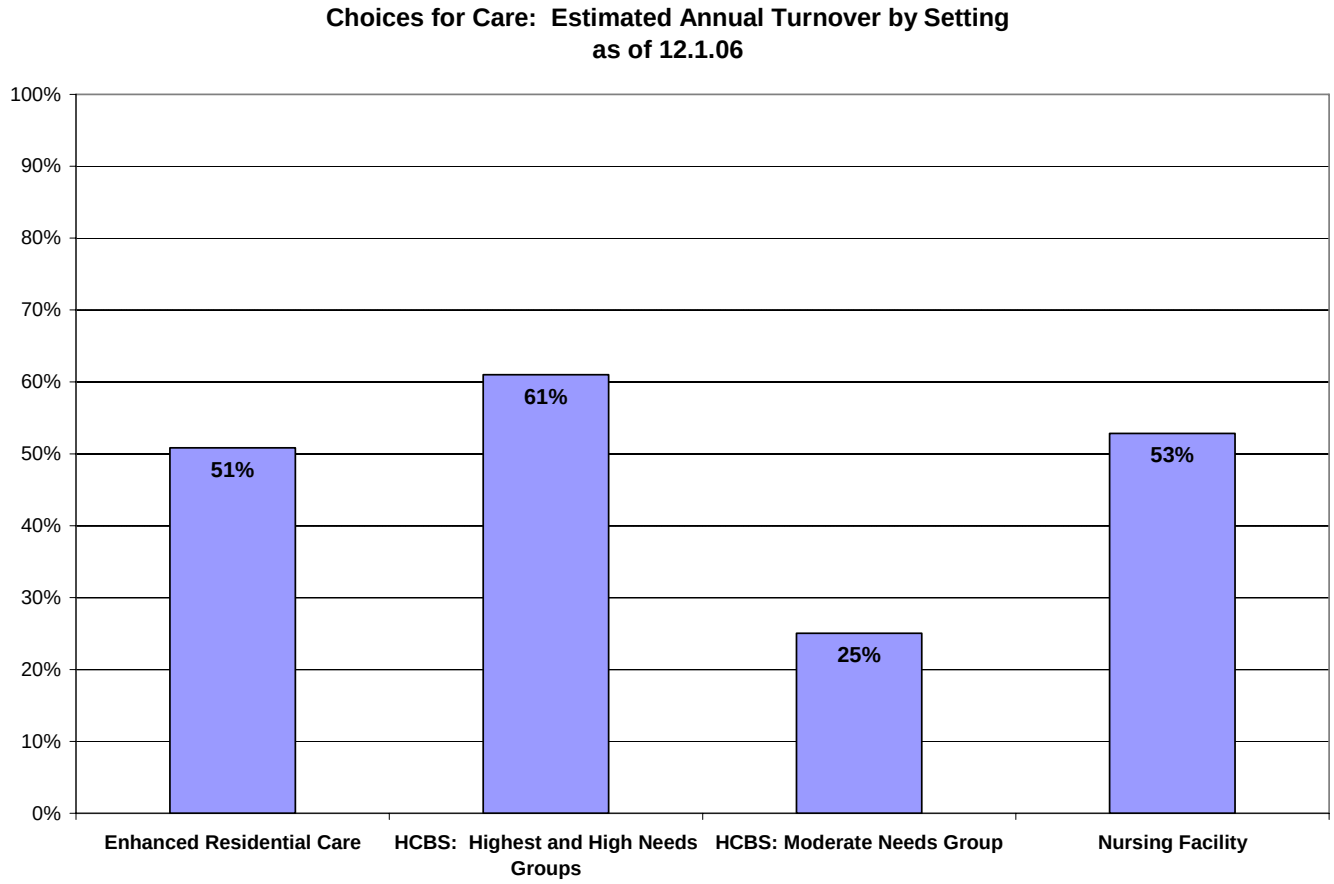
Choices for Care: High Needs Waiting List Outcomes as of 11/29/06

(160 people on waiting list since October, 2005)



Data source: DAIL/DDAS SAMS database.

This graph shows the outcomes for all applicants who have ever been on the Choices for Care Waiting List. Of all applicants, 65% remained on the waiting list as of December 1, 2006, while 28% had been enrolled in Choices for Care.



Data source: DAIL/DDAS SAMS database.

'Turnover' in each setting is computed by dividing the estimated number of participants who are disenrolled in a year by the number of people served at a point in time.

During the first eleven months of Choices for Care, the highest turnover was found among the Highest and High Needs Groups in the Home and Community Based setting. Turnover rates in Nursing Facilities and Enhanced Residential Care settings were very similar. As expected, turnover in the Moderate Needs Group was the lowest of all groups.

Choices for Care: Denials and Disenrollments, Year 1 (October 2005 - September 2006)

Denials

	Moderate	HCBS	ERC	NF	Undetermined	*TOTAL*
Ineligible for LOC	0	61	6	3	6	*76*
Ineligible for Medicaid	1	17	2	16	0	*36*
Other	1	14	0	7	3	*25*
No Medicaid application	0	9	1	8	0	*18*
Needs Met by Other Program	0	1	0	1	0	*2*
Voluntary (Estate Recovery)	0	1	0	0	0	*1*
TOTAL	*2*	*103*	*9*	*35*	*9*	*158*

Disenrollments

	Moderate	HCBS	ERC	NF	Undetermined	*TOTAL*
Died	21	255	35	664	21	*996*
Other	55	162	17	131	46	*411*
Moved to NH	16	139	52	*na*	1	*208*
Moved to HCBS	?	*na*	6	183	0	*189*
Ineligible for Medicaid	1	20	4	27	1	*53*
Moved to ERC	1	26	*na*	18	0	*45*
Ineligible for LOC	6	17	1	14	5	*43*
Changed LOC	4	20	3	7	0	*34*
Needs Met by Other Program	7	8	2	7	5	*29*
Moved out of state	3	8	2	11	0	*24*
Hospitalized	2	1	1	10	0	*14*
Voluntary (Estate Recovery)	0	9	0	1	0	*10*
Family Will Provide Care	0	1	0	1	1	*3*
TOTAL	*116*	*666*	*123*	*1074*	*80*	*2059*

Data source: DAIL/DDAS SAMS database; duplicated counts of individuals

This table shows the reasons that applications were denied and enrollments ended.

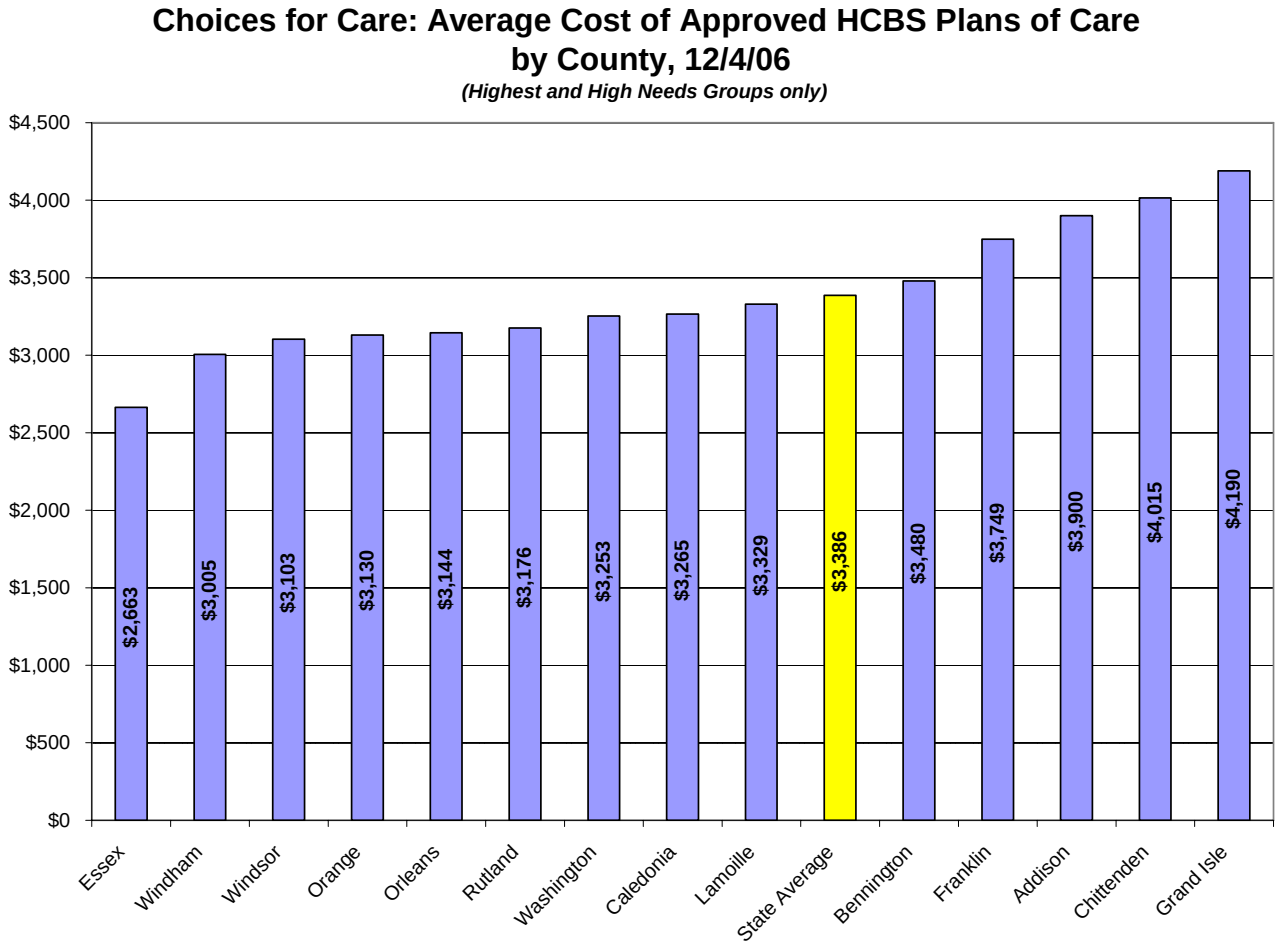
Denials:

More applications for the HCBS Highest and High Needs Groups were denied than for any other setting. The most common reasons for denials were Ineligible for Level of Care, representing 38% of all denials, and Ineligible for Long Term Care Medicaid, representing 23% of the total.

Disenrollments:

Death was the leading cause of disenrollment across all settings, representing 48% of the total. Large numbers of participants moved from one setting to another:

1. Nursing Facilities: 183 people moved to HCBS, and 18 people moved to ERC.
2. HCBS: 139 people moved to Nursing Facilities, and 26 people moved to ERC.
3. ERC: 52 people moved to Nursing Facilities, and 6 people moved to HCBS.

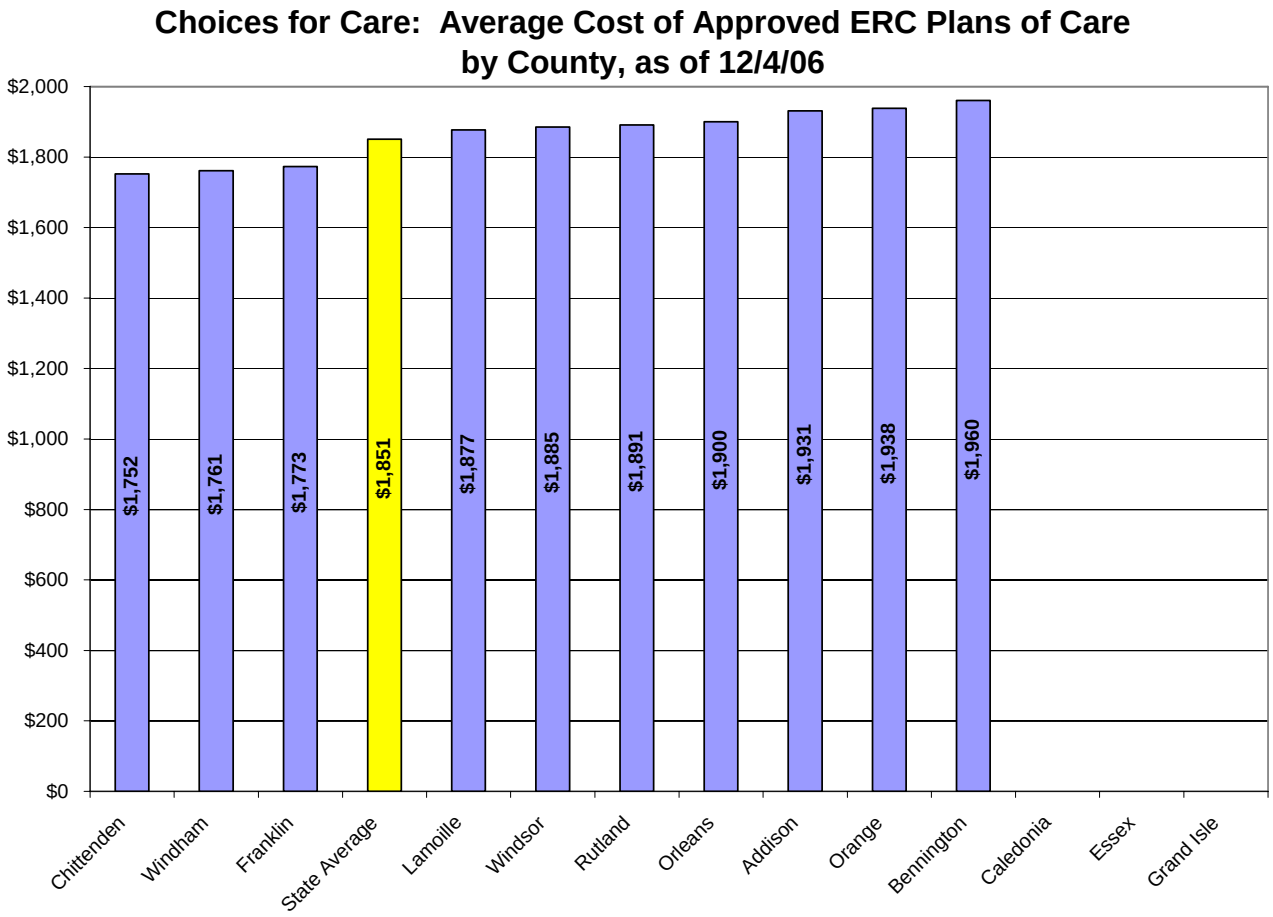


Data source: DAIL/DDAS SAMS database.

The average approved cost of HCBS Highest/High Needs Group Plans of Care was $3,386. The average costs in three counties (Grand Isle, Chittenden, and Addison) were at least 10% above the state average. The average costs in two counties (Essex and Windham) were at least 10% below the state average.

The available evidence suggests that several factors can contribute to higher costs of Choices for Care individual plans of care, including:

1. Greater use of Home Health Agency personal care services, at a higher reimbursement rate.
2. Higher volumes of personal care services.
3. Greater use of adult day services.
4. Lower use of home health services (nursing and licensed nurse assistants) supported by Medicare or Medicaid.

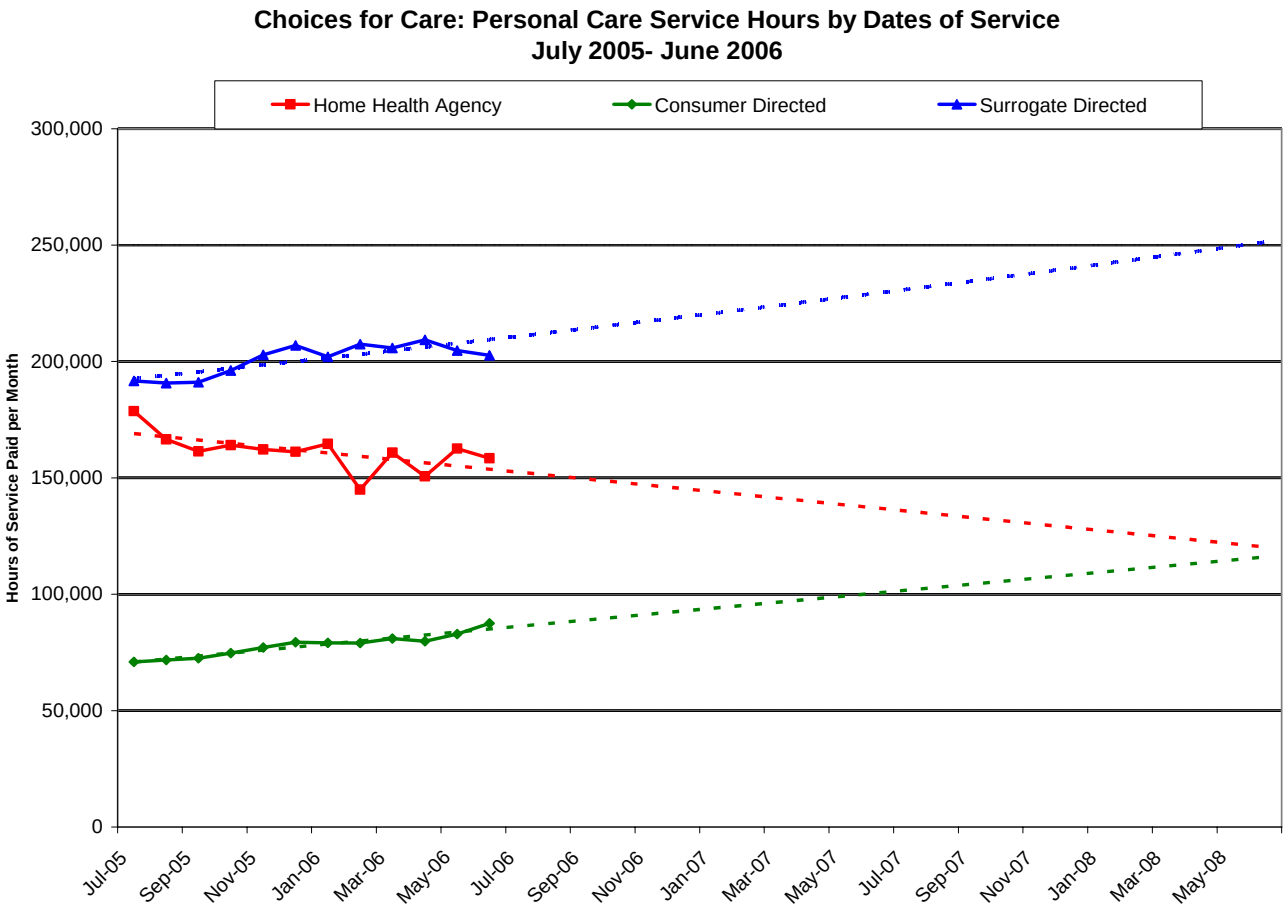


Data source: DAIL/DDAS SAMS database.

The average approved cost of ERC Highest/High Needs Group plans of care was $1,861. This is about 45% less than the average approved cost of HCBS plans of care. The highest costs were found in Bennington, Orange, Addison, and Orleans counties. The lowest costs were founding Chittenden, Windham and Franklin counties.

There is no consistent relationship between approved HCBS costs and approved ERC costs by county. Addison and Bennington counties had high ERC plan of care costs as well as high HCBS plan of care costs. Chittenden and Franklin counties had low ERC plan of care costs but high HCBS plan of care costs.

The range of ERC plan of care costs is smaller because fewer factors contribute to the differences. ERC plans of care are based on three distinct daily reimbursement 'tiers', which directly reflect the functional and cognitive status of ERC participants but do not represent a specific number of hours of personal care. ERC plans of care do not include adult day services, which contributes to some higher HCBS plan of care costs.



Data source: EDS paid claims, by date of service
Note: consumer and surrogate directed data adjusted to reflect two payperiods in all months (reducing total actual number of hours in three months).

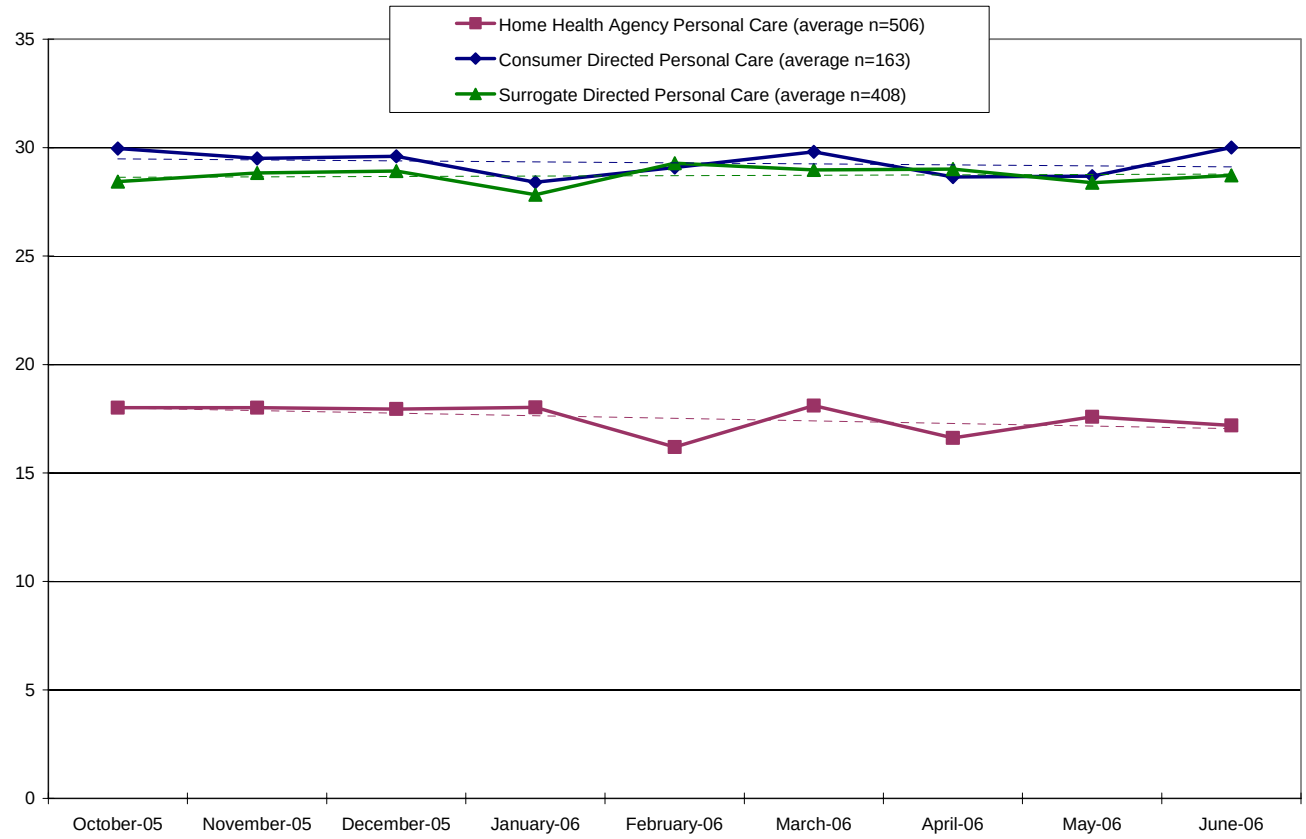
This graph shows trends in the three different Choices for Care personal care service options: home health agency, consumer-directed, and surrogate-directed.

Consistent with the trends established prior to Choices for Care, substantial growth continues in consumer-directed and surrogate-directed personal care services. Combined, consumer-directed and surrogate-directed personal care services represent about 65% of the personal care services that are actually provided. These personal care services cost about $12 million less than the same services would have cost if provided through an agency at a higher reimbursement rate.

Possible implications include:

1. Continued growth in a 'non-traditional' caregiver workforce, including family and friends.
2. Need for training and support of consumer and surrogate employers.
3. Need for training and support of consumer and surrogate directed caregivers
4. A continued 'moderating' influence of lower hourly reimbursement of consumer and surrogate directed services on the total cost of Choices for Care personal care services.

Choices for Care Personal Care: Average Hours of Actual Services per Week for People Who Received Services, October 2005 - June 2006



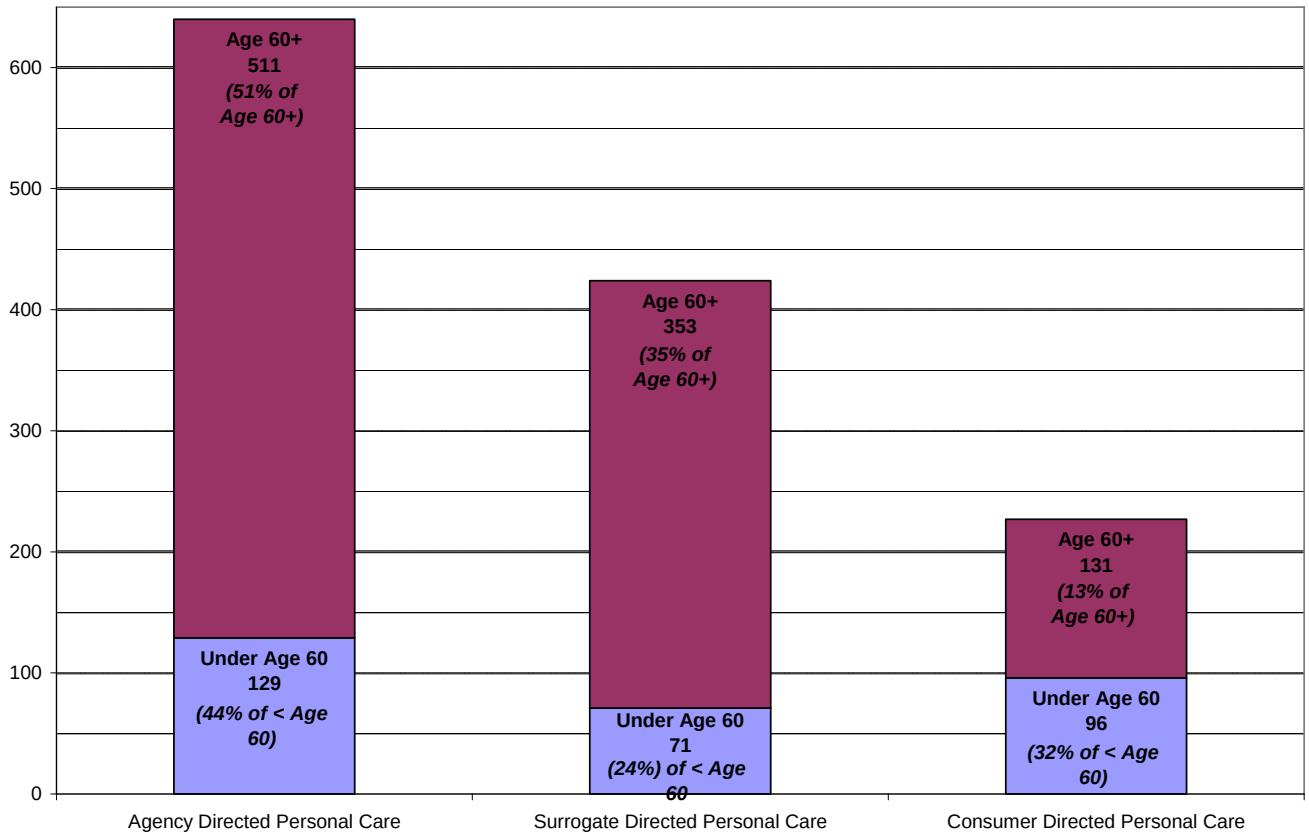
Data source: EDS paid claims, by date of service

This graph represents the actual number of hours of personal care services provided to Choices for Care participants, by personal care service option. The data shows a slow decrease in the average number of hours of personal care services delivered per person across all service options.

The data also shows that the average number of hours provided to participants under the home health agency option is substantially less than the average number of hours provided under the consumer directed and surrogate directed options. Factors that appear to contribute to this difference include:

1. A higher percentage of caregivers in the consumer and surrogate directed options are friends and family members, making them more available to provide paid services on different days or at different times and locations.
2. Home health agencies may have more difficulty providing personal care staff at specific locations.
3. People receiving home health personal care may be more likely to receive other similar services through the agency, including licensed nursing assistant services. These services are paid by Medicare or Medicaid, but are not provided through Choices for Care.

Choices for Care Personal Care Services: Age of Active Participants by Type of Service
as of 11.28.06



Data source: DAIL/DDAS SAMS database.

This illustrates the ages of people who chose the three different personal care service options. Conventional wisdom suggests that a much higher percentage of older people will choose agency services than younger persons. The percentage of people in each age group who use agency services is actually similar: 51% of people age 60 and over, and 44% of people under age 60.

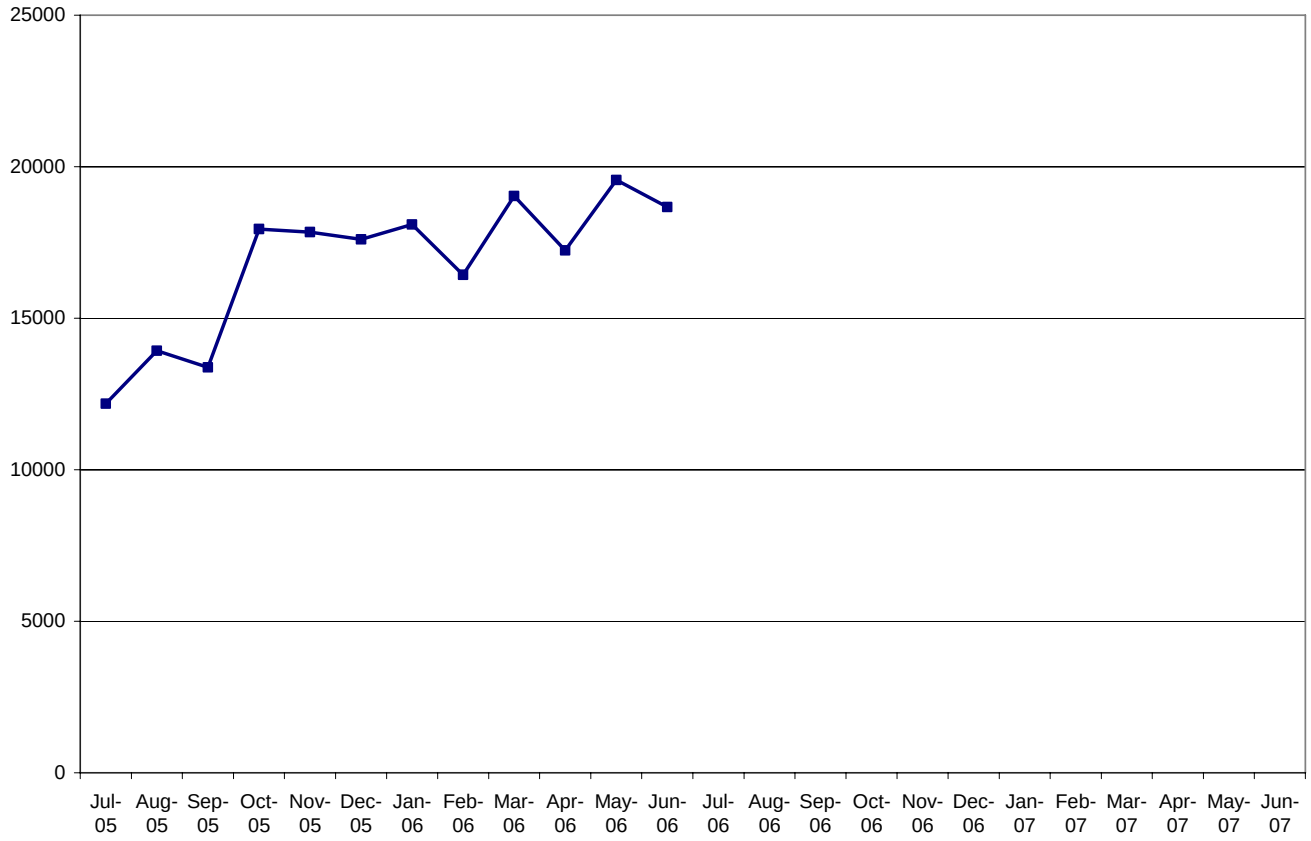
There are more substantial differences between the two age groups in the other service options. Older people (35%) are more likely to use surrogate directed services than younger people (24%). Younger people (32%) are more likely to use consumer directed services than older people (13%).

The median age of people enrolled in the HCBS Highest/High Needs Groups is nearly 80. Due to the large number of older people enrolled in Choices for Care, older people outnumber younger people in every service option.

As of December 2006, the median ages of people enrolled in Choices for Care by setting were as follows: ERC, 87 years; Nursing Home, 85 years; Short Term Nursing Home, 80 years; HCBS Moderate Needs, 77 years; HCBS Highest/High Needs, 76 years.

Choices for Care: Adult Day Service Hours by Month, July 2005- June 2006

(includes Highest, High, and Moderate Needs Groups; also includes Adult Day Respite Care)



Data source: EDS paid claims by dates of service

This graph shows increased use of adult day services supported by Medicaid long term care during the 2006 state fiscal year. The data includes services provided to the Moderate Needs Group, the new eligibility group that was created in Choices for Care in October 2005.

Between January 2006 and June 2006, adult day programs provided about 4,700 hours of service each month to people in the Moderate Needs Group. During this same time period, adult day programs provided an average of about 13,400 hours of service each month to people enrolled in the Highest and High Needs Groups.